



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DALLAS MEDICAL CENTER
7 MEDICAL PARKWAY
DALLAS TX 75234

Respondent Name

LIBERTY INSURANCE CORPORATION

Carrier's Austin Representative Box

Box Number 1

MFDR Tracking Number

M4-12-0303-01

MFDR Date Received

September 26, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We show this claim to have been sent 3 times for correct payment per the Work comp fee schedule, based on Medicare Reimbursement and is still not paid correctly, the 3rd request was sent and denied as being past the 11 month deadline."

Amount in Dispute: \$4,509.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "we will continue to deny CPT 29807 (labral repair) as not documented as performed. . . . This statement does not document a repair of the labrum. This statement documents a debridement of the labrum . . . Liberty Mutual believes that Dallas Medical Center has been appropriately reimbursed for services rendered . . ."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 8, 2010	Hospital Outpatient Services	\$4,509.01	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)

- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
- B291 – THIS IS A BUNDLED OR NON COVERED PROCEDURE BASED ON MEDICARE GUIDELINES; NO SEPARATE PAYMENT ALLOWED. (B291)
- U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES.
- B377 – THIS IS A BUNDLED PROCEDURE; NO SEPARATE PAYMENT ALLOWED.
- Z345 – LEFT SIDE. (Z345)
- U849 – THIS MULTIPLE PROCEDURE WAS REDUCED 50%% ACCORDING TO FEE SCHEDULE OR USUAL AND CUSTOMARY GUIDELINES. (U849)
- X901 – DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED. (X901)
- U401 – THIS MULTIPLE PROCEDURE WAS REDUCED 50 PERCENT ACCORDING TO FEE SCHEDULE OR USUAL AND CUSTOMARY GUIDELINES. (U401)

Issue

Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is July 8, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on September 26, 2011. This date is later than one year after the date of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by either party to this dispute have not been addressed.

Authorized Signature

<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Signature	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Grayson Richardson Medical Fee Dispute Resolution Officer	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> October 11, 2012 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party.***

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.